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FOR THE PHYSICIAN IN GENERAL PRACTICE



ALCOHOLISM—Pages 31-42

SCHWARTING

THE
PSYCHIATRIC
BULLETIN

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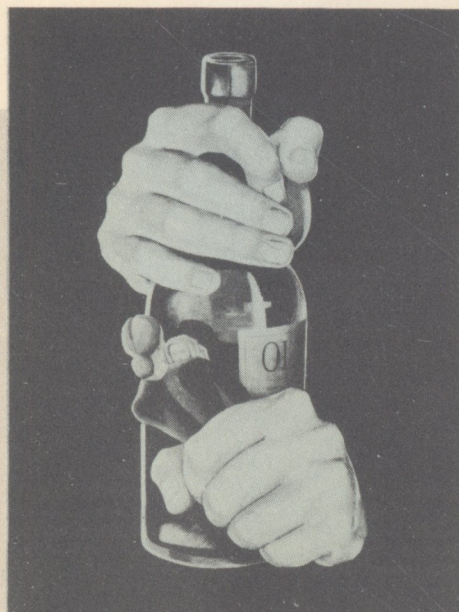
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THE COVER

The painting on the cover depicts relative values in the life of the alcoholic as he gradually abandons his loyalties and responsibilities in favor of his growing need for alcohol. The center section of this issue is devoted to six articles on alcoholism, beginning on page 31.

The cover painting was executed by Mr. Joseph Schwarting.

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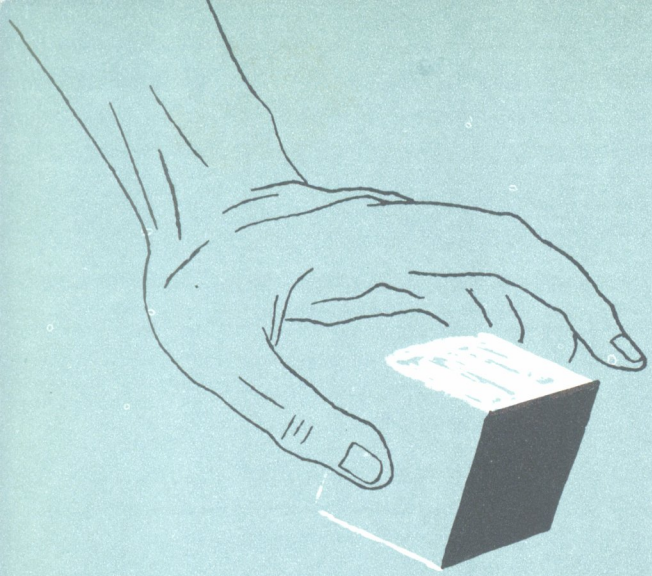


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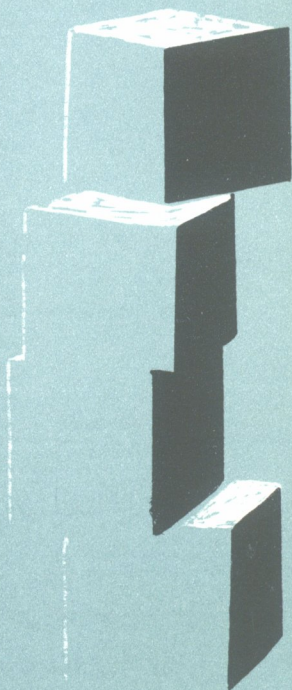
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e retarded child

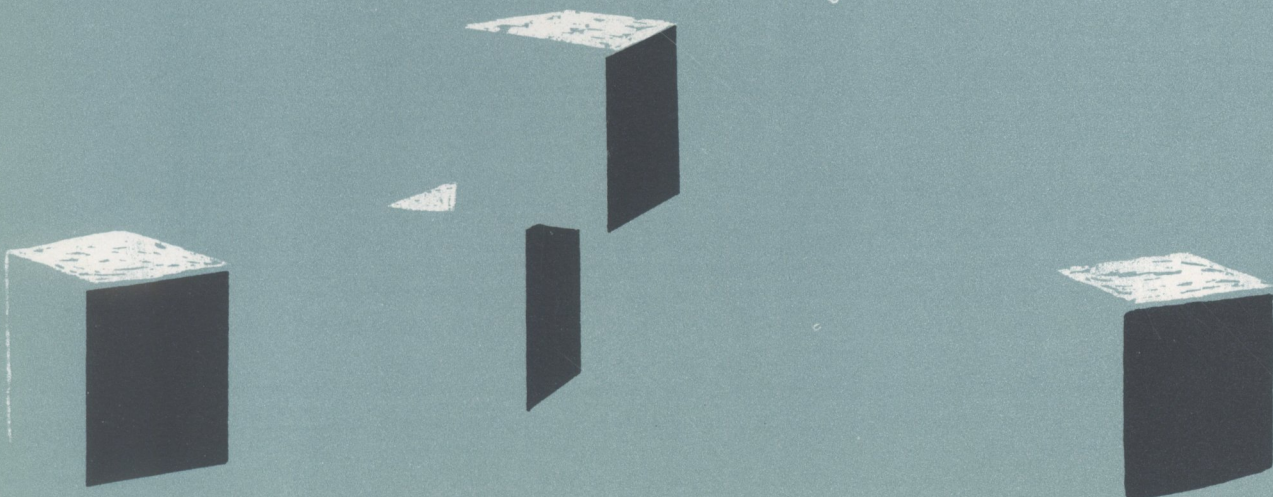
FROM TIME IMMEMORIAL the retarded child has been the object of public pity and scorn. In the clinic, too, he often encounters an attitude of hopelessness and indifference. Those who sincerely seek to aid him are additionally burdened by the established but inadequate classification of mental defectives.

The classification in common usage for the past four decades is based upon performance in a revised version of the Stanford-Binet intelligence tests. Originating in France and introduced into the United States at the Vineland Training School,

these tests were designed to estimate and compare the relative intellectual capacities of children. A child's mental age was estimated on the basis of his test performance in comparison with that of average children of his age. Any discrepancy above or below the "norm" was expressed by means of a ratio, called the intelligence quotient, or I. Q. Children with an I. Q. of 25 and under were termed idiots; those whose I. Q. fell between 25 and 50 were deemed imbeciles; and those whose I. Q. remained between 50 and 70 were designated morons. The newer nomenclature,

with less stigmatizing designations of mild, moderate and severe, is also based on I. Q. ratings.

Despite the long usage of these ratings, many authorities feel that distribution of defectives on an arbitrary man-made scale is not clinically helpful. The main objection to dependence on such ratings is that more significant medical, social and psychiatric findings are thereby overlooked. Concepts more in keeping with recognized clinical facts have been suggested. A workable classification should take into consideration symptoms, etiology and prognosis.



Several new groupings have been suggested and a variety of terms for each category have been set forth. Regardless of the terminology eventually used, the more useful groupings reduce the problem to a consideration of abnormal, subnormal and misleading clinical symptoms.

Abnormal Are in the Minority

The common denominator of the abnormal feeble-minded group is some structural anomaly or pathological condition of the central nervous system. This is the conclusion, based upon 250 post-mortem examinations, of Benda and his associates at the Waverly Training School. The pathological condition may arise from defective germ plasm, deprivations during uterine life, birth trauma, or life experiences. The resulting mental state, however, is not a process of normal development of learning. It is a mental defect comparable to the physical abnormality with which it is associated. The idiot and imbecile have no place on a normal intelligence scale.

Familiar congenital types are Mongolians, cretins, and microcephalics. Any other condition of gross mental defect as a result of brain tissue destruction would also be included in this group.

The irreversible nature of this condition, however, does not warrant the social and professional neglect which these individuals are sometimes accorded. It has been sagely observed, "not one of us could survive unharmed the daily frustrations of the feeble-minded". These frustrations can be lessened to some extent by consistent training aimed at the patient's self-care.

Case History of an Abnormal Child

A resourceful mother describes the habit training of her defective daughter, Mary. In addition to being feeble-minded, Mary was also spastic. Both conditions were attributed to birth injury during prolonged labor.

Almost from the beginning, the child's backwardness was apparent. She made no attempt to sit up before the end of the first year, nor had she cut a single tooth. She did not walk until well into the third year, and at four, was not yet toilet-trained. The gentle persistence required for successful training is reported by this

mother, who says, "*Rhythm and routine are the only substitutes for an active brain*".

The problem of cleanliness was first undertaken. The little girl was carried to the bathroom on schedule at lengthening intervals, until she was able to pass the whole night without an accident.

A feeding routine was similarly imposed. When the child finally cut her teeth, she showed no inclination to use them. Normally, even a sucking infant has a tendency to bite, but this seriously retarded baby only learned to chew at all through drills and games. Patiently, the parents demonstrated the use of teeth through exaggerating their own chewing movements. Next Mary learned to handle a spoon by a "game" of transferring peas from one bowl to another. When at last Mary could grasp a spoon, the mother filled it with honey and guided it to the child's mouth. The mother reports, "The necessary washing of face, and clothes, and hair was well worth while".

Under this type of special training, Mary fulfilled what potentialities she had. She still requires support and supervision, but, at 21, she is able to go on simple errands alone and has the satisfaction of earning spending money with her hand work.

Many retarded children may remain vegetative because they are encouraged to do so. The parent who finds it simpler to wait on his retarded child than to train him is not acting in the best interests of the child.

Fortunately, defectives of this type comprise the minority of feeble-minded. Being few in number, they are not a major social problem. Nor is heredity considered a prominent factor. Most of them are incapable of reproduction and many do not live to adulthood. Intellectual defect is only a part of their gross pathological condition.

Hopeful prospects for the prevention of pathological mental defect lie in the direction of constructive research. Two developments of the past decade appear significant. These are: discovery of the Rh blood factor and the role of rubella during pregnancy.

Mental retardation associated with microcephaly is considered now to

be among the possible effects of rubella in the mother during early pregnancy. This discovery should reduce one phase of the prevention of feeble-mindedness to the control of a communicable disease.

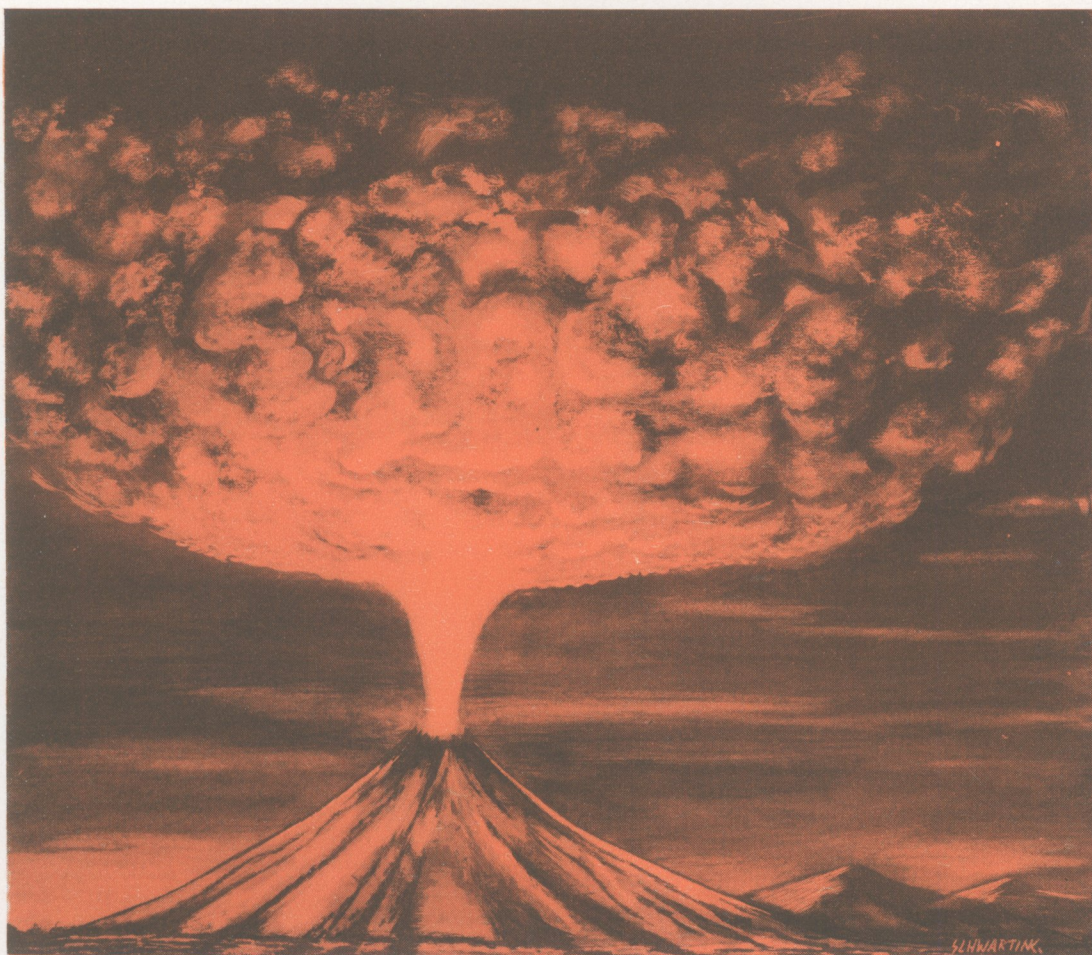
Regarding the Rh factor, Davison reports that Rh positive children of Rh negative mothers constitute eight per cent of the feeble-minded. The means are at hand to regulate this condition. The physiology of the Rh factor can be demonstrated clinically. Hence, reduction of mental deficiency resulting from incompatible Rh factors may one day be accomplished through an effective educational program. The family physician has a unique opportunity here. Most physicians are alert to the consequence of Rh sensitization by previous pregnancies. However, insufficient attention may have been paid to Rh sensitization as a result of blood transfusions. Johnson states that sensitization is *ten times more likely to occur from incompatible transfusions than from incompatible Rh matings*. The female population might well be encouraged to ascertain their blood types early in life. Then the Rh negative woman could be advised not to undergo any elective blood transfusions.

Experimental research in a number of separate studies reports encouraging results from glutamic acid therapy. Investigators report improved behavior and performance of mental defectives and in some cases, a measurable increase in the I. Q. rating. Some workers hold that the observed rise in I. Q. may be partially attributed to better emotional control, which allows more efficient utilization of the existing intellect. Even though it has been demonstrated that patients failed to hold their gains upon withdrawal of the medication, the administration of this drug may reduce the total disability long enough to render the patient accessible for training.

Subnormal Child Can Be Socialized

The mentally subnormal are at the bottom of the normal scale in the distribution of intellect. They are, however, a part of that scale. Even Goddard, who first supplied the term "moron", says that the definition no longer applies which originally differentiated these from the rest of the

Please turn to page 43



Case History

no. 2181

A 39-year-old farmer was referred to the psychiatrist for complaints of periodic vomiting, severe retching, and excessive salivation. The attacks came on suddenly without apparent cause, were unrelated to meals, and occurred at any time of day. They came on while he was doing hard physical work, while hunting, and while resting quietly at home. The family physician had done exhaustive studies for organic disease with entirely negative findings.

HISTORY: The patient had started having these attacks some eight years previously, but until about three years before they had occurred only two or three times a year. At the time that he was referred to the

psychiatrist, the attacks were occurring once or twice a week, lasting from five to 30 minutes. His general health otherwise had been good, with no significant weight loss, food intolerance, or disturbance in elimination.

The patient was born on a Texas farm, the fourth of seven children, and grew up in extreme poverty. The father was a part-time preacher who demanded of his children immediate and unquestioning obedience; each child had assigned chores by the age of five and was working in the fields by age seven. Impertinence or talking back was punished by severe beating and a pious lecture about "Honor thy father and mother". As he approached his teens, the patient began to see that the father was a

poor manager and was irresponsible. Leaving the children to do the work, he frequently spent days away from the farm, ostensibly "on God's business", but actually on a fishing excursion or loafing in town. The final blow came when, at age 17, the patient learned that the father had been having an affair for years with a middle-aged widow who lived nearby. The patient impulsively ran away and for several years did not communicate with his family. During these years he worked in the oil fields, took to drinking heavily, became sexually promiscuous, and acquired a reputation as a quick-tempered character, handy with his fists and dangerous when drunk. In his fourth year of oil field work the patient got news his father had died suddenly of a heart attack. He returned home immediately and took part in running the farm, assuming the main responsibility for his mother's support. He stopped drinking, and studiously avoided any arguments or unpleasant situations, in order to keep out of fights. On the one or two occasions when he did get into fights he was profoundly remorseful afterward. He joined the church and there met a girl whom he married at age 23. A year later they had a girl baby, and by the time the patient was 28 they had acquired a small farm of their own. They continued to prosper but the patient became more and more tight-fisted with money. His primary interest was in getting more land, more cattle, and more money in the bank, and he begrudged every cent spent for clothes, for fixing up the house, or for entertainment. This became a major bone of contention between him and his wife, who was an attractive person with many friends, more than usually interested in "keeping up with the Joneses". The issue became a sort of contest of wills between them, and after an unusually heated disagreement they separated temporarily after seven years of marriage. The wife filed suit for divorce and moved back with her parents. She made sure her husband found out that several young men came inquiring about her availability for dates, and as she anticipated, the husband reacted to this news by coming to her and begging her to come back on any terms. She kept him in doubt

for a time and rather enjoyed his ardent courtship. She let him spend the night with her three or four times but delayed going back to live with him until it became apparent she was pregnant with their second child. It was shortly before this child, a son, was born that the husband's vomiting attacks began.

TREATMENT: The above information was obtained in the first two interviews. The patient then was asked to investigate with the psychiatrist the possibility that some sort of emotional crises were connected with the vomiting attacks. A few examples from everyday experiences were cited to show how bodily changes accompany emotional stress. Blushing in embarrassment, tears with grief, the trembling, palpitation, sweaty palms, and stomach quivering with fright were mentioned. His attitude at this point could best be described as skeptical but willing to give it a try. In the next three or four sessions he recounted many of the incidents in which vomiting had occurred. Once when his cattle broke out of the corral he started vomiting while saddling a horse to round them up. Another time an attack started just after the arrival of some relatives who had a habit of overstaying their welcome. Yet another one started when a boy friend came by for his daughter, now 15; the patient matter-of-factly stated he had to tell the boy to come to the door in the future instead of just blowing the auto horn, but he insisted that the incident did not bother him. He made quite a point of his ability to keep his self-control; he had learned as a young man "it didn't get you anywhere to fly off the handle, and besides it just showed weakness to let your feelings get the best of you." His statement was accepted uncritically and he was asked to tell about other situations where his self-control came in handy. By a round-about approach he brought up the matter of a farmers' cooperative organization in which he had been active. The head of the group, an older man, had been in power for years and ran the organization with an iron hand. The patient had differed sharply with him on several matters of policy and on the use of funds but could make no progress

against him. As he related the situation the patient became visibly upset, started perspiring, and finally in a burst of feeling unusual for him, said "I'm so damn tired of his pushing us around, I can't stomach much more". When asked to repeat what he had just said, he looked puzzled, then said "Well, I'll be damned. Maybe we're getting somewhere".

This was a definite turning point in therapy and the patient rapidly discovered his vomiting spells always resulted from smothered rage or hostility. As he learned more about how he felt he found that he could express his feelings outwardly or not, depending on the circumstances, and still avoid the upheaval of his G.I. tract. He ultimately recalled that his symptoms first began after the marital reconciliation while his wife was pregnant. One day after an argument he had the thought "How do I know this is my child anyhow? Maybe she's playing me for a sucker." He became quite agitated, could not get the idea out of his mind, and had a siege of vomiting. He admitted having had strong feelings of hostility toward the boy almost from his birth. As his son grew and began to assert himself occasionally, the patient had further trouble, and many vomiting attacks were related to having to discipline the boy. The patient commented that his son's behavior reminded him of himself as a boy. He derived considerable reassurance from this thought. The high-handed cooperative president was seen to be emotionally linked with the arbitrary, domineering father.

At the tenth weekly interview the patient spontaneously suggested that he try it on his own for a while. He was by then having only occasional and very mild recurrences of symptoms and seemed to be learning something from each episode. Although it was apparent that there were still many gaps and unanswered questions, a termination of treatment was agreed upon with the understanding that interviews might be resumed if things did not go well. A year has elapsed and he still feels competent to handle things alone and is having no particular difficulty.

DISCUSSION: One of the most important reasons for the successful outcome of this patient is the manner in which the original referral was handled. His physician, a physician in general practice, showed his genuine interest first by taking a careful history and then by a thorough and methodical examination. He then discussed the findings frankly with the patient, telling him no adequate explanation for the symptoms had yet been found. Consultation with a psychiatrist was suggested by pointing out that the examination could not be considered really complete until the possibility of an emotional reaction had been explored. Without laboring the point, he gave the patient the idea that this was a customary part of a complete examination in all cases where the cause of symptoms was not easy to locate. By avoiding any premature attempt to "sell" the patient on a diagnosis of emotional illness before the facts were at hand, the physician kept the patient's defensive resistances to a minimum.

Capitalizing on this favorable beginning, the psychiatrist allowed the patient's story to unfold itself and avoided premature or sweeping interpretations. The psychiatrist perceived the connection between hostile impulses and vomiting very early, but felt that it would have been a serious error to confront the patient with this information at the time. *The patient needed to discover it for himself* with unobtrusive guidance; in this manner the discovery had emotional as well as intellectual impact and validity.

Many significant areas of this man's emotional life were left almost totally unexplored. This was deliberate, since the goal of therapy was symptomatic improvement rather than a sweeping restructuring of the personality. He brought up material indicating the presence of strong unconscious homosexual conflicts and there was also evidence that his beautiful and prematurely developed daughter was arousing some disturbing sexual feelings. Both these areas were avoided since no long-term therapy was contemplated. Often successful short-term symptomatic therapy hinges on the careful choice of what fields *not* to explore further.

ALCOHOLISM





Alcoholism

FOR CENTURIES, the victim of chronic alcoholism has been regarded with either amused indulgence or undisguised contempt. Only in recent years has he come to be considered a sick person in need of medical help. Indeed, so long as alcoholism was regarded as a moral issue, its gravity as an illness escaped both laymen and physicians. The long-standing popular attitude toward pathological drinking is illustrated by Bogen's description of the progressive stages of intoxication, based upon the concentration of alcohol in the blood.

The first phase he describes as "dry and decent", for, with a concentration of less than one milligram, signs of alcohol consumption may not be clinically perceptible. The three successive stages, labeled "delighted and devilish", "delinquent and disgusting", and "dizzy and delirious", are said to result from concentrations of one to three milligrams, respectively. The individual is termed "dazed and dejected" with a concentration of three to four milligrams, and he is "dead drunk" when the alcoholic concentration reaches five milligrams. This is perilously close to lethal concentration, for

death may occur when it rises to six milligrams and over.

Since the medical profession now regards the alcoholic as within its province, it becomes necessary to clarify what is understood by the term, "alcoholic".

It has been estimated that approximately 95 per cent of those who drink remain moderate drinkers throughout their lives. Of the remaining five per cent, some drink more than they can handle from time to time and suffer inconvenience and discomfort from their excess. Still, these are not what the medical profession now recognizes as "alcoholics." Only about one per cent of those who drink become *compulsive* drinkers in the sense that drinking is a symptom of their need to escape some painful aspect of reality. It is this type to whom the term "alcoholic" is generally applied.

Among the questions which legitimately may be asked is "how is one to know when a person's drinking has become compulsive?" This is best determined by estimating how much the habit is costing the drinker, in terms of disruption of his life.

Everyone who lives in a community of his fellow men is subject

to certain demands and personal loyalties. Family, vocation, friends and many other associations influence the behavior of the average person. Medical men long have recognized that the victims of narcotic addiction desert their fixed loyalties, sacrificing money, prestige and personal relationships to the craving which consumes them. The compulsion to drink which characterizes the alcoholic has been likened to an addiction, with certain notable exceptions. For one, the physiological craving which distinguishes narcotic addiction does not prevail. Also, no physical tolerance to alcohol develops. On the contrary, a physical intolerance eventually seems to occur. The alcoholic cannot compound indefinitely the amount of alcohol ingested because its sedative effect invariably produces unconsciousness upon the attainment of a given concentration in the blood. Nor can the so-called "withdrawal symptoms" of alcohol be classed with the clinical manifestations produced by narcotic withdrawal, despite the discomforting aftermath of a prolonged drinking bout. It is only in the dissolution of the individual's life pattern that the compulsion of the alcoholic can be said to approach the proportions of an addiction.

Disregarding their personal welfare, alcoholics may drink steadily for days, weeks, or even months, taking little or no nourishment at the time. Anyone who observes them

as an illness

objectively in the midst of one of these sieges will readily agree that they are sick. Too often, however, such patients are not observed objectively. Rather, they are maligned, condemned, and lectured on a "better way of life". These measures are usually of little therapeutic value.

Adequate management of the alcoholic patient includes immediate physical treatment plus long-term psychological reorientation. Often the greatest obstacle is encountered in convincing the *patient himself* that he is a sick person instead of a scoundrel. The element of remorse must be ferreted out of the patient's mind, for one of his chief reasons for seeking refuge in alcohol is to deaden the pangs of his own re-creation. The compulsion to drink as a means of escaping reality cannot be overcome so long as the patient is burdened with self-reproach. His sickness should be revealed to him, not as an alibi for his episodes of poor judgment, but as a justification for abstinence and an incentive to recovery. Once this change in attitude is achieved by the alcoholic, his chances of re-establishing his life on a positive footing are tremendously improved. Indeed, it may be justly claimed that there is no chronic illness for which the recovery rate is so high, provided alcoholism is recognized in its true perspective and the patient receives the understanding handling of a truly objective physician.



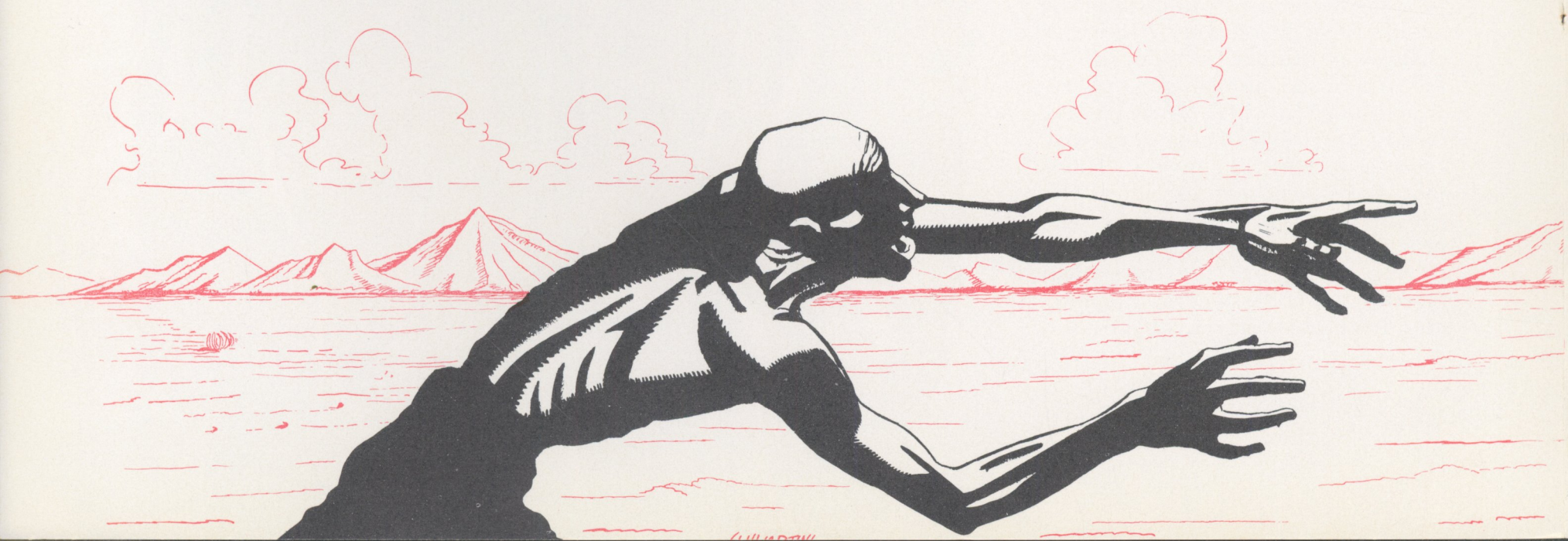
various theories on the

ETIOLOGY of alcoholism

THE CHANGING TREND in the attitude of medical men toward alcoholism becomes all the more evident upon examining the evolution of etiological concepts of the disease. Less than a generation ago, the condition now recognized as alcoholism was believed by almost everyone to stem from nothing more than "*pure cussedness*". Even those who were sufficiently humanitarian as to withhold direct censure still felt that the major causative element at work was "*human frailty*". This impression

doubtless gained impetus from the glaring discrepancies in individual susceptibility to problem drinking. Indeed, if "*human frailty*" were understood in terms of some improper functioning of the psychobiological unit, instead of a dereliction of the moral fibre, it would contain an apt description of current scientific thought. For not all those who drink heavily, or even steadily, will become alcoholics whose uncontrolled drinking follows a pattern deleterious to the continuation of a successful life.

It is obvious that the difficulty lies in the man who indulges to excess, rather than in the means of excess selected. Some people eat too much; others daydream too much, and still others lean too heavily on drugs, whether stimulants or sedatives. If they employ these devices in order to escape some factor of reality they cannot bear to face, then it may well be assumed that "*human frailty*" is at work. However, men of scientific and inquiring minds no longer ascribe this "*frailty*" entirely to the



conscious will of man. Instead, they are seeking possible causes outside the realm of purely willful behavior.

One of the more easily-invoked scapegoats, of course, always is heredity. This view finds adherents because of the higher incidence of alcoholism among certain families and certain races. Nevertheless it cannot be overlooked that environmental conditions also may find strong parallel within the same family and even within certain races. In fairness to the patient, prognosis is much more hopeful if some cause other than heredity is determined for pathological drinking.

Inevitably, the biochemistry of the individual had to come under consideration. Hundreds of laboratory tests were accumulated and compared. Large numbers of alcoholics showed striking evidence of *malnutrition* and *vitamin deficiency*. A theory was advanced to the effect that when these deficiencies reach a certain level, controlled drinking veers off and is replaced by compulsive drinking. The assumption followed that, if the incriminating deficiencies could be restored, the compulsion would disappear, and the individual once again would be enabled to "drink like other people". Research in this direction is still in the experimental stage. As in all scientific research, many years of study and thousands of case histories will be required before a definite conclusion regarding this theory is acceptable to all.

There is another theory under study, which claims both a tentative etiology and an easily administered therapy. This theory is based upon

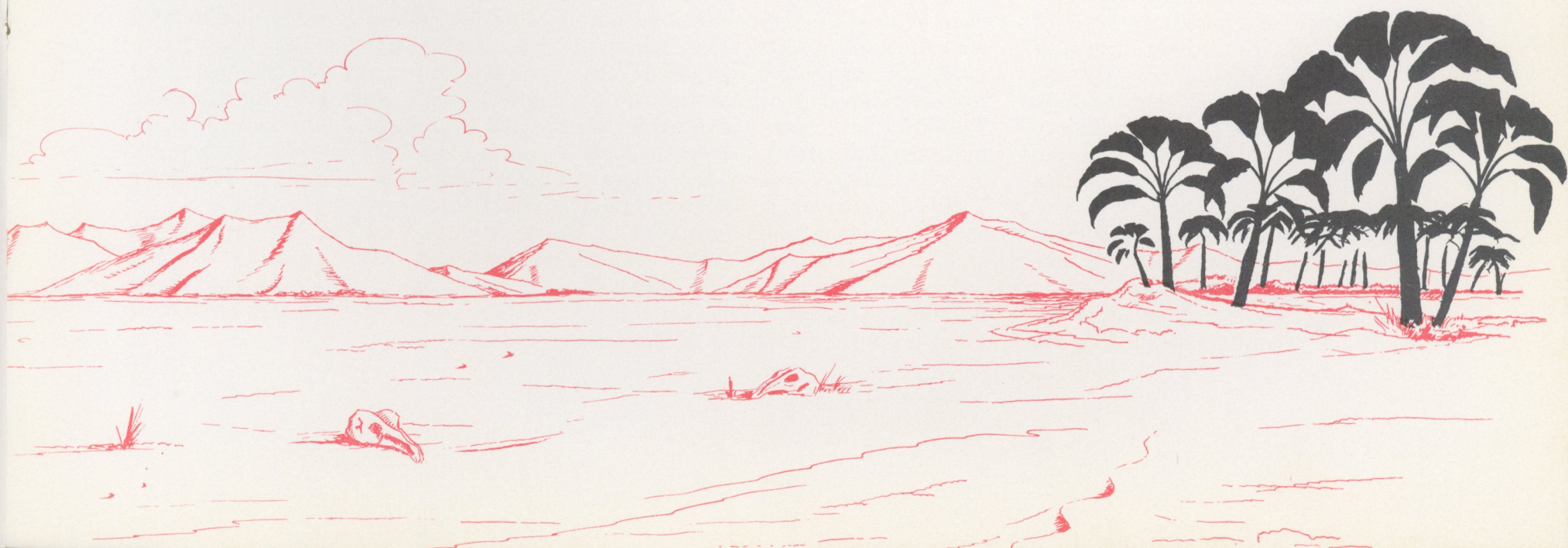
a premise of adrenal cortical insufficiency, or *hypoadrenocorticism*. According to this theory, adrenal hypofunction forms a physiological basis for the craving for alcohol. Accompanying this deficiency are symptoms of uneasiness, worry, fear, or anxiety. These emotions in turn are said to contribute to further deficiencies in the functioning of the adrenal cortex. An attempt is made to re-establish the correct endocrine balance by the administration of adrenal cortex extract, or its synthetic form, Cortisone. While this therapy does much to alleviate the immediate toxic symptoms, it has not proved effective in eradicating the compulsion to drink. While the incidence of hypoadrenocorticism is high among alcoholics, laboratory tests indicate that alcohol tends to aggravate the condition. Therefore, it may be that adrenal cortical deficiency is more an end result than a cause of alcoholism.

Abandoning physiological factors as an explanation for the compulsion to drink, there is the vast realm of disorders of the mind to be explored.

Only a slight departure from the idea of willful dereliction is necessary to attribute alcoholism to a "*psychopathic personality*", as some psychiatrically-oriented authorities did for a time. The term "psychopath" was once widely used to signify those criminal delinquents who fail to develop any moral responsibility or sense of guilt. It was soon evident that the alcoholic did not belong in this category chiefly because his sense of guilt is not only intact but painfully acute. In fact, careful analysis of the combined reports of

organized research on the personality characteristics of alcoholics establishes but one conclusion, "*there is no alcoholic personality prior to alcoholism*".

Investigators trained in psychiatric methods explain alcoholism on the basis of a *neurosis*, brought about by painful conflicts. In everyone, there is a balance between the stresses of the environment and the ability of the mind to cope with them. This balance is more precarious than usual in the neurotic. The more neurotic a person is, the more elaborate a system of defenses is required to equalize the pressure of his hopes and fears. As years go by, it is common for some hopes to weaken, and thus become outweighed by fears. Defenses which have served in the past are no longer effective in dealing with the stresses of each day. One of the simplest escapes to fall back on is alcohol—with its accessory conviviality, its transient euphoria and its promise of oblivion. Whatever the source of the basic conflict, the patient must be enabled to deal with it positively before he can afford to dispense with his established means of defense. Psychiatric therapy combines several avenues of approach to the problem of neurotic defenses. The approach is directed to resolution of the basic conflicts; it seeks methods for modifying stresses prevailing in the environment; and it provides a means for helping the patient develop stronger resources with which to meet life. The therapist skilled in psychiatric technique will converge all these methods on the problem simultaneously in the management of the alcoholic.



Conditioned Reflex and Antabuse Therapy

IN 1940, Lemere and Voegtlin presented their "conditioned reflex" therapy for alcoholism. This treatment employs Pavlov's principle that aversion to a given stimulus may be developed through repeated association with unpleasant effects. In an effort to condition him to dislike alcohol in any form, the patient is dosed with a powerful emetic, following which he is plied with alcoholic beverages of all sorts. Nausea and vomiting result. The procedure is repeated five times in the course of ten days with follow-up courses given after a month or two. The intent of this treatment is to produce a permanent aversion to alcohol, but as Pavlov himself noted, conditioning is spontaneously reversible and the conditioned reflex tends to become extinct with the passage of time if the stimulus is not continued. Therefore a program of reinforcement was recommended. Recognizing the likelihood of relapse during the first year, Voegtlin advocated that treatments be administered periodically for at

least one year. In their initial report of results following the use of this method, the investigators state that of 685 patients treated, 64 per cent remained abstinent for a period of four years or longer.

Seven years later, Voegtlin presented a study of some 4,000 alcoholic patients treated by this method and followed for ten years. Relapses which had occurred between the fourth and tenth years lowered the abstinence rate to 50 per cent. Voegtlin concluded that "physical and social rehabilitation, formal psychotherapy, and other specialized procedures were necessary" to supplement the conditioned reflex treatment.

Antabuse (tetraethylthiuram disulfide) was presented by Jacobsen and his associates in Denmark in 1948. First regarded as a "miracle drug", it received wide publicity both in the United States and abroad. Unlike emetine, *Antabuse* taken alone produces no ill effects, except in those conditions for which it is



contraindicated. Mixed with alcohol, however, it invariably produces severe toxic reactions.

Antabuse inhibits the normal metabolism of alcohol in the body, resulting in an increased acetaldehyde concentration in the blood. It also affects the enzyme systems of the liver, but it does not affect the rate of alcohol elimination from the body. When alcohol is taken after Antabuse, the symptoms are dual in character. First, the symptoms resulting from the accumulation of acetaldehyde in the blood are: increased pulse rate, decreased blood pressure, flushing, and changes in the electrocardiogram. Second are the symptoms resulting from the direct influence of Antabuse upon the body: motor restlessness, sensation of suffocation, apprehension, headache, pallor, weakness, nausea, and vomiting. The intensity and duration of symptoms depend upon the dosage used, the amount of alcohol taken, and the individual response. Prolonged therapy does not produce tolerance to the drug, for the longer Antabuse is taken, the more acute is the reaction to alcohol.

Recent investigators have found ascorbic acid to be a useful adjunct to Antabuse therapy. Administered in oral doses of one milligram, ascorbic acid has been reported to relieve the secondary symptoms of restlessness, apprehension, headache, and weakness. Although ascorbic acid makes the patient more comfortable, it does not alleviate the more important symptoms, such as nausea, lowered blood pressure, and the rise in pulse rate.

Contraindications to the Use of Antabuse

There are several major contraindications to the use of Antabuse, both physiological and psychological.

Antabuse is definitely contraindicated in coronary or myocardial disease, hyperthyroidism, cirrhosis of the liver, nephritis, diabetes mellitus, pregnancy, epilepsy, and psychosis.

Before it is administered, the patient's general status should be evaluated with particular regard to cardiac, hepatic and renal function. After a careful clinical evaluation is made, the physician may order specific laboratory tests as needed. One or more of the following may be indicated: blood count, urinalysis, blood serology, glucose tolerance test, blood sugar, blood urea nitrogen, liver function tests, electrocardiogram, or BMR.

Particular caution must be exercised when alcoholism is complicated by narcotic addiction. There is evidence that Antabuse prolongs barbiturate action and therefore use of sedatives should be carefully restricted in this group. Antabuse should never be given to patients in conjunction with paraldehyde.

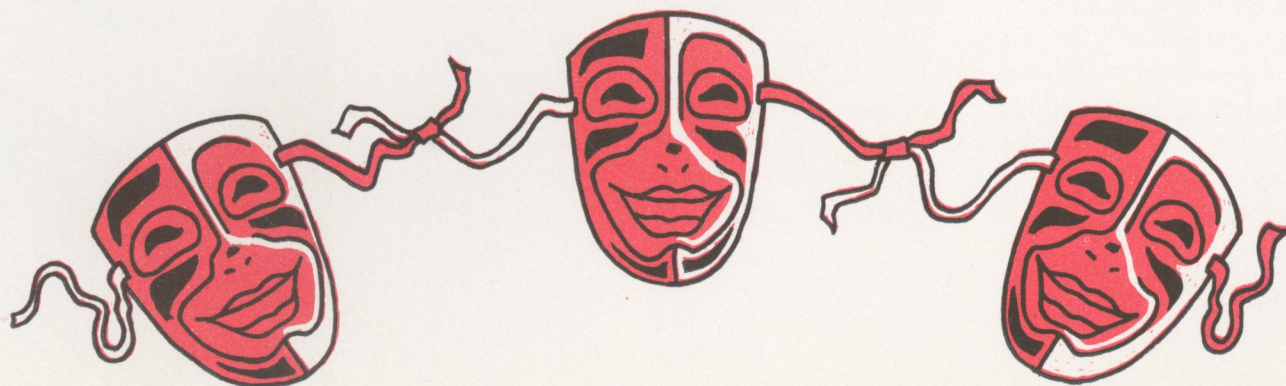
One of the risks of Antabuse therapy is that of treating patients with unrecognized organic disturbances. Obviously, there is the danger of complication in patients who develop myocardial insufficiency during the course of treatment. Since strict and constant medical supervision is required for safe administration of Antabuse, such therapy can become hazardous to individuals treated on an out-patient basis. There is the ever-present danger of emergency resulting from surreptitious drinking which may occur without access to immediate treatment. According to Fox, Antabuse "*should never be given without the patient's full knowledge and consent. Otherwise, death could occur from the rapid drinking of 2-3 ounces of whiskey*". It has been recommended that an identification card be carried by any patient who is taking Antabuse, indicating the symptoms likely to occur after alcohol consumption, first aid measures, and the name of the physician to be called in case of emergency.

The use of Antabuse as a control of the compulsion to drink is psychologically imperfect, because the patient has two avenues of "escape".

Any time he wants or needs to, he may stop taking the drug and begin drinking again. Even when his medication is supervised and enforced by external influence, the patient may steel himself to becoming deathly sick and drink in spite of this certain danger. Indeed, many patients have knowingly endangered their lives in this manner.

There is the further danger of psychosis occurring following the removal of alcohol which has been used as a crutch in persons with poorly developed personality defenses. Despite the acknowledged difficulty of establishing etiological factors which are frequently unconscious in nature, the treatment and prognosis are largely dependent on the cause. With some patients, symptomatic treatment may achieve gratifying results. But in those cases in which alcoholism is a crutch to reinforce a thoroughly unstable personality, removal of this prop without anything to take its place may cause the patient to resort to an even less desirable means of escape. In such cases psychotherapy directed to the underlying maladjustment is a necessity.

Whatever treatment is used, it is certain that alcoholics cannot be successfully treated on a wholesale basis. As noted by Seliger, "Society has erred by discussing alcoholism instead of the individual alcoholic". *So much remains unknown about the motivations of the individual man and woman that a many-sided empirical approach seems justified in every case.* Only careful study and continued observation of each patient will eventually dictate the therapy best suited to the individual patient. A thorough knowledge of the various pharmacological therapies is of inestimable value, yet there will always be some patients who fail to benefit from these alone. Even in these cases, however, physiological therapy remains of value as an adjunct to psychotherapy in the management of alcoholism.





THE ROLE OF

Psychotherapy

IN ALCOHOLISM

SINCE ALL compulsive drinkers tend to follow a common behavior pattern, it is difficult to appreciate their basic differences. The conspicuous common denominator—alcoholism—masks the true personality, whether it be relatively normal, neurotic, psychopathic, or overtly psychotic. For this reason, the role of psychotherapy in alcoholism is indistinct. With patients in whom

the drinking is clearly a neurotic symptom, intensive psychotherapy may be expected to achieve favorable results. The low recovery rate which deep psychotherapy has recorded (between 10 and 15 per cent, according to Tiebout) may be accounted for on the basis of failure to select patients who need this type of treatment, or insufficient diligence and skill in the use of the method.

In some instances, less intensive psychotherapy, directed at the relief of current tensions, is more appropriate in the management of the chronic alcoholic.

Regardless of the pre-alcoholic personality structure, many emotional problems are superimposed on the individual, once his drinking reaches a compulsive stage. These include feelings of guilt and remorse,



fear of the disapproval of others, and a strong suspicion of worthlessness of self, all of which are temporarily eased by taking further refuge in drink. This cycle must be broken before any other difficulties can be successfully attacked.

One of the stumbling blocks to effective psychotherapy has been the difficulty in establishing rapport. "A physician could not possibly understand my problem, because he has never been in my position", the patient thinks. Probably the major reason for the success of such organizations as Alcoholics Anonymous in the United States and the Blue Cross Society in Europe and Scandinavia is the lack of condemnation which one alcoholic feels toward another. The physician may carefully erase the impression of his own aloofness by permissive acceptance of the patient during the therapeutic sessions. In addition, he will want to minimize the patient's feeling of stigma attached to his drinking. Tremendous relief is afforded the guilt-ridden patient when he learns that he is sick, but not hopelessly so, and that many others have had the same sickness, but have learned to prevent its interference in their lives.

The goal of therapy is permanent separation from alcohol. At first, however, the goal of the patient himself is to be able to drink with impunity. Only recently has it been recognized that a person can be a heavy drinker, but one fully in control of his drinking for many years; then suddenly, and without any awareness of the change, can slip into the compulsive category. When this occurs, he can no longer drink as normal people do. Since he does not know this, he goes right on trying. This does not mean that he is weak, or wicked, or mentally ill—it is merely a personal peculiarity. One day medical science may be able to eradicate this phenomenon, but until that is achieved, certain individuals simply cannot handle liquor.

If a patient has any doubt as to whether or not he falls into this category, the physician may show him the 34 diagnostic questions drawn up by the Department of Psychiatry at Johns Hopkins University which help to identify the alcoholic. These include such queries as, "Do you require a drink the next morning?",

"Do you prefer to drink alone?" "Is drinking jeopardizing your job, or your family's welfare?" "Do you ever have to take a drink even when you know it is not expedient for you to do so?"

It usually requires much time and the traumatic effects of many tragic circumstances before the patient is willing to acknowledge the need for total abstinence. This has been referred to by Tiebout as "the act of surrender", and in more common language by Alcoholics Anonymous as "hitting bottom". Indeed, it might be well to examine the points of similarity and those of departure between the techniques of this spectacular laymen's organization and those of formal psychotherapy.

Much of the A. A. program consists of superficial, but sound, psychotherapy. Rapport is a foregone conclusion, by virtue of the membership requirements. Acknowledgment of the need to be helped is a basic factor in both psychotherapy and A. A. Another common psychotherapeutic measure employed by Alcoholics Anonymous is self-analysis and ventilation of the troublesome circumstances of one's life. The reassurances of group therapy are brought to bear on the individual during this phase of mental catharsis.

Unique in the A. A. program is the matter of cutting the problem down to the size one can grapple with. The failure of much well-directed psychotherapy may be laid to the unwillingness of the patient to accept the fact that he cannot take liquor in any form. A. A. circumvents the need for total acceptance of this dismal fact by a sort of compromise. They tell the alcoholic that his problem is a matter of the here and now. No one knows what is in store for the future, but they claim that anyone can be responsible for one day. They recommend that their members try to maintain abstinence for "24 hours at a time".

Also unique is the A. A.'s emphasis on the recognition of a "greater power". However, as Ruth Wilson so aptly puts it, "they find it relatively easy to accept some greater power since every alcoholic has already met one—John Barleycorn". Whether described as a spiritual experience or the attainment of emotional insight, the individual has

to feel the need for seeking a new direction in life.

One of the factors producing strain in the alcoholic is social maladjustment, which is further intensified by his drinking pattern. The physician knows how greatly his patient needs the emotional support of friendly social contacts. Yet it is difficult to provide a ready-made environment appropriate to his needs. In A. A. new contacts can be made in which social ostracism is not the penalty for an occasional slip. Opportunities for fun and recreation are available and it is important for the alcoholic to find these before he lapses into a dangerous state of boredom.

The consumption of alcohol accounts for huge periods of time in the life of the chronic alcoholic. When this pastime is abolished, the individual may have on his hands a dismaying surplus of hours. Bird points out that to remove an alcoholic's liquor without giving him something else to take its place is "as cruel and useless as turning one's back on a cripple after taking his crutches".

Up to this point, the parallel between the efforts of psychotherapy and those of Alcoholics Anonymous is fairly constant. Their methods diverge as the members of A. A. embark upon their final step. Having experienced a profound personality change, attained new self-realization, and accomplished an undreamed-of measure of self-discipline, the successful A. A. member usually accepts a part in the crusade of the group. This is embodied in their pledge "to carry this message to alcoholics and practice these principles in all our affairs". The message they carry is the recitation of their own experience. As such, it inspires faith in others, who see living proof that their own difficulty can be overcome.

The family physician can be instrumental in guiding the alcoholic through the perilous transition into a new and gratifying way of life. The patient can be shown that his drinking has deteriorated from a pleasant social custom into a destructive compulsion. He may be led to realize that drinking has become an influence even more compelling than his loyalty to family, friends and job. Even these facts may be insufficient to bring about the will to

change. Frequently, before the alcoholic really wants to stop he must see that he is doing irreparable harm *to himself*; indeed that *his own life* is being destroyed. Whether thought of as an act of surrender or "hitting bottom", the turning place must be reached in the patient's mind before he can set about to re-establish his life without the use of alcohol. This decision is beset with misgivings. Many a busy physician would be justified in becoming impatient with the patient in this stage of ambivalence. Yet, this is the crucial point in therapy, when most of all the patient needs a door that is always open and a fellow man who is always ready to accept and understand his behavior problem.

Only when it is certain that the patient wants to change are the members of Alcoholics Anonymous able to help him. The critical stage of vacillation is the physician's province, and this is the point at which he can provide the emotional support that sustains hope, and leads to the acceptance of a new way of life. He may be gratified by seeing his patient transformed from utter dependence on alcohol, compensated by blustering self-aggrandizement, into a self-reliant individual, tempered with the humility of his experience. And, as Dr. Andrew Tomb pointed out to a group of physicians, "You will not find in any phase of practice a more grateful group of people".



Alcoholism in Industry

THE CHANGING ATTITUDES of members of the medical profession toward alcoholism is reflected in the concepts held by certain industrial leaders. Several of the large industrial firms have instituted a program of relief and rehabilitation for problem drinkers in their employ. Among these are Consolidated Edison, Bell Telephone Company and Allis-Chalmers. The experience of the latter firm is reported, not with the intent of minimizing the contribution of other firms, but to illustrate what any large employer can accomplish toward the constructive assistance of its alcoholic employees.

Officials of Allis-Chalmers noted several years ago that most of their disciplinary problems centered around excessive drinking. The majority of men so involved had been with the company for ten or more years before drinking finally incapacitated them for efficient work. Since the firm has such a large investment in their training, it is deemed more economical to attempt

rehabilitation of such men than to train new ones for their jobs.

The approach is twofold. First, there is an educational program for those in a supervisory capacity. Supervisors are informed that the attitude of the management is that the alcoholic is sick and needs help, rather than discipline. The firm employs a full-time alcoholic counselor to co-ordinate the many services available for helping employees who have a drinking problem. It is emphasized that referral to the alcoholic counselor is not in any way a disciplinary action, but one in the best interests of the employee.

The program for the alcoholic employee is one of sympathetic understanding and positive aid. The alcoholic counselor is fully capable of appreciating the individual's problem, since he is a former secretary of Alcoholics Anonymous. In the first interview, he discusses with the referred employee any problems he is aware of which disturb him and complicate his life. In many cases, the drinking stems largely

from situational pressures which can be reversed with a little aid. Legal, financial, housing and domestic difficulties are frequently encountered. Facilities are available to improve the situation in many instances. If the problem does not appear to be situational, the psychological counselor is called upon to examine the employee. Underlying emotional weaknesses may be uncovered, in which case appropriate psychotherapy, consisting of reassurance, persuasion and diversion, may be recommended. Some employees are introduced to A. A. Only if they remain intractable are their services terminated. Even then, if the loss of employment provides the jolt that leads to a reversal of the drinking pattern, the company policy is to re-employ them without prejudice. Rather than an extravagance, this policy of dealing with alcoholics is regarded as a sound investment by the officials of Allis-Chalmers, who claim that immeasurable benefit has been realized in terms of lowered absenteeism and salvaged skill.

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THE RETARDED CHILD

Continued from page 28

population. Under present methods of education and training, the so-called moron is not, as once supposed, "incapable of competing with his fellow men nor of handling his affairs with ordinary prudence".

Case History of a Subnormal Child

Whitney, of the Elwyn Training School, cites a characteristic example. Charlie, a low-grade moron, failed to exceed 54 on repeated I. Q. tests.

In early life Charlie had been neglected by his parents, who were themselves subnormal. He arrived at Elwyn undernourished, with bad teeth and tonsils, rales in his lungs and vermin in his hair. The school authorities went to work on his reversible ills. They had his tonsils removed, his teeth repaired, and placed him on the regimen for T. B. care. He responded at once to his improved environment. Despite tremendous handicaps, the boy had manual dexterity and a well-directed emotional drive. Within a year he was actively participating in school sports and manual training classes. He became captain of two athletic squads and played a cornet in the band. Notwithstanding such activities, his intellectual limitations precluded formal schooling beyond the second grade. Nevertheless, his other assets enabled him to learn the plastering trade. Today, he excels as a skilled laborer.

Although service in World War II shattered the minds of many "normal" individuals, this "feeble-minded" boy found in it a means of establishing economic security. In the Army he handled his interpersonal relations with such success that he was able to induce another soldier to go into business with him. The business partner figures their contracts because of Charlie's "lack of education", but he says that Charlie is the better artisan. Such accomplishments encourage all those who work with retarded children. As Zilboorg says, "It seems to be one of man's greatest intellectual weaknesses not to be able to understand that intellect alone is not the decisive factor in his behavior".

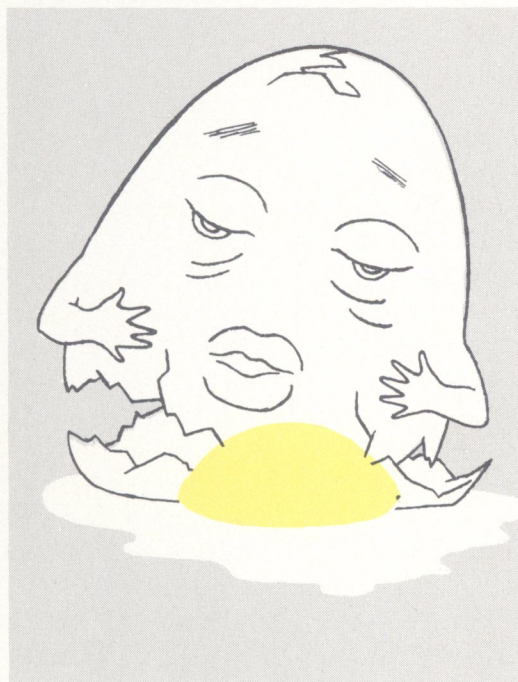
The independent social adjustment of some mental defectives

astounds case workers. Follow-up studies in Minnesota of 147 retarded pupils revealed that most of them had obtained their own employment. With I. Q. ratings between 50 and 75, they had not sought jobs traditionally assigned to the mentally retarded. Many of them worked in industry, operating machines at a wage rate up to \$1.10 per hour.

It is an axiom of rehabilitation workers that there are more jobs for the mentally retarded to do than there are retarded people to do them.

Other Disorders Can Masquerade as Feeble-mindedness

It is sometimes hard to differentiate between a feeble-minded child



and a potentially normal one with diagnostic signs suggesting mental deficiency. Deafness, visual defects, speech and reading dysfunction and autism may present outward signs suggesting mental impairment. In addition, schizophrenia and certain emotional disorders may block normal development of the intellect. Recognition of past diagnostic errors justifies a careful restudy of doubtful cases in which the patient was deemed feeble-minded. In some cases so reviewed, positive therapeutic measures on an individual basis may result in a surprising increase in the child's functioning intelligence. Such errors commonly occur when too much reliance has been placed upon

the I. Q. rating alone. One test score is never sufficient evidence for relegating a child to the category of feeble-mindedness.

Case History of a Child Falsely Designated Feeble-minded

In childhood, Floyd had been considered a mental defective, since his I. Q. rating was only 50. His poverty-stricken background included a drunken mother, a criminal father and five siblings in the county home. His personal history contained truancy and petty delinquency, as well as malnutrition, anemia, hyperactive reflexes, and bad teeth and tonsils. Nevertheless, he responded surprisingly well to the controlled environment of the training school. He excelled in sports and music and, with his subsequent improvement in morale, he showed an unsuspected capacity for academic learning. Belatedly, he was able to complete the eighth grade of school, and his I. Q. rating indicated a final score of 75. When asked why he had performed so poorly on previous tests, he replied, "If that fellow didn't know the answers, I wasn't going to help him".

In this instance it is probable that the first testing provided unreliable results leading to an incorrect evaluation of Floyd's intellectual capacity.

In the war, he survived Sicily, Salerno, and the Battle of the Bulge. As a Staff Sergeant in the U. S. Army, he trained other selectees. Floyd's case particularly emphasizes the fact that emotional factors may belie the immutability of I. Q. ratings.

Differential diagnosis may be further complicated when true feeble-mindedness appears in combination with transitory disorders. The retarded child is first of all a human being. With reduced capacity, he is even more susceptible than others to manifold physical and emotional ills. Those individuals who are inadequately endowed are especially susceptible to mental ailments.

It is reported by Pollock that of 444 mentally defective patients admitted to New York State Civil Hospitals in 1942, only 5 per cent were without superimposed neuroses or

psychoses. The annual rate of admission for psychotic patients was seven times greater among the mentally defective than among the general population. He concludes that the rate of mental disease increases as the degree of intelligence declines. This offers a tangible possibility to ameliorate the condition of many mental defectives, since their psychiatric disorders are frequently shallow and transitory, responding well to suitable psychotherapy.

Psychotherapy for the Parents

The parents of a retarded child usually need counseling. If they are fighting against the acknowledgment that their child will never be normal, they may desperately need emotional support. While nothing can be gained by holding out false hopes, actual damage can be done by informing the parents too bluntly of the child's condition. It has been the experience of many that parents angrily repudiate the first physician who presents them with irrefutable evidence of their child's retardation. The most logical reason for this is that emotional forces are at work in the minds of both parents. Erroneously, they often feel a deep sense of guilt and embarrassment, which the physician can help to allay.

Jensen notes that while most parents suspect their child's retardation, few will mention it as a presenting symptom. Nevertheless, under discreet questioning, the physician may soon elicit their doubts and guide them into a realization of the facts. Much of their feeling of guilt can be dispelled by pointing out that they are in no way responsible for accidents of nature and emphasizing that they have an additional duty to one another and to the rest of their family. They may also feel guilty because they love the afflicted child less than they believe they should. Overcompensation for their own feelings of guilt causes some parents to resist any suggestion to place the abnormal child in an institution. This reaction can often be modified by careful avoidance of words with emotional connotation. Parents who recoil at the words "idiot" and "commitment" might readily accept the same idea if presented in such terms as "handicapped" and "suitable placement." Such parents are wont to procrastinate and exhaust their funds by going from clinic to faith healer to quack, in search of a "miracle" cure. They let years go by in this manner—important years from the child's standpoint—and end with a teen-age child who has missed the opportunity for training appropriate to its basic needs.

To prevent this, much depends upon the approach of the family physician. If he is able to deal sympathetically with the positive aspects of routine care for these afflicted children, he not only saves himself patients but he saves parents the fruitless expense of visits to specialists all over the land.

That parents can face this problem objectively has been demonstrated by recent group action. Many

parents of mentally retarded children are finding group security for themselves and their offspring in the National Association for Retarded Children. Marino, one of their officers, says the problem of retardation can be met only by first activating the parents of retarded children. Bewildered parents might well be referred to one of its many local chapters. Here, they can forget self-pity in a program of constructive cooperation. Parents who fully accept the knowledge of their children's limitations and face the reality of their own situation are able to give a measure of fortitude to other parents who need it. They seek as a group to provide public education suitable for retarded children and to assure continued care for the children of all members, even in the event of the parents' death.

As Deso Weiss points out to the parents of similarly handicapped young patients, the question is no longer, "what can society expect of the retarded child", but "*what can the retarded child expect from society?*"

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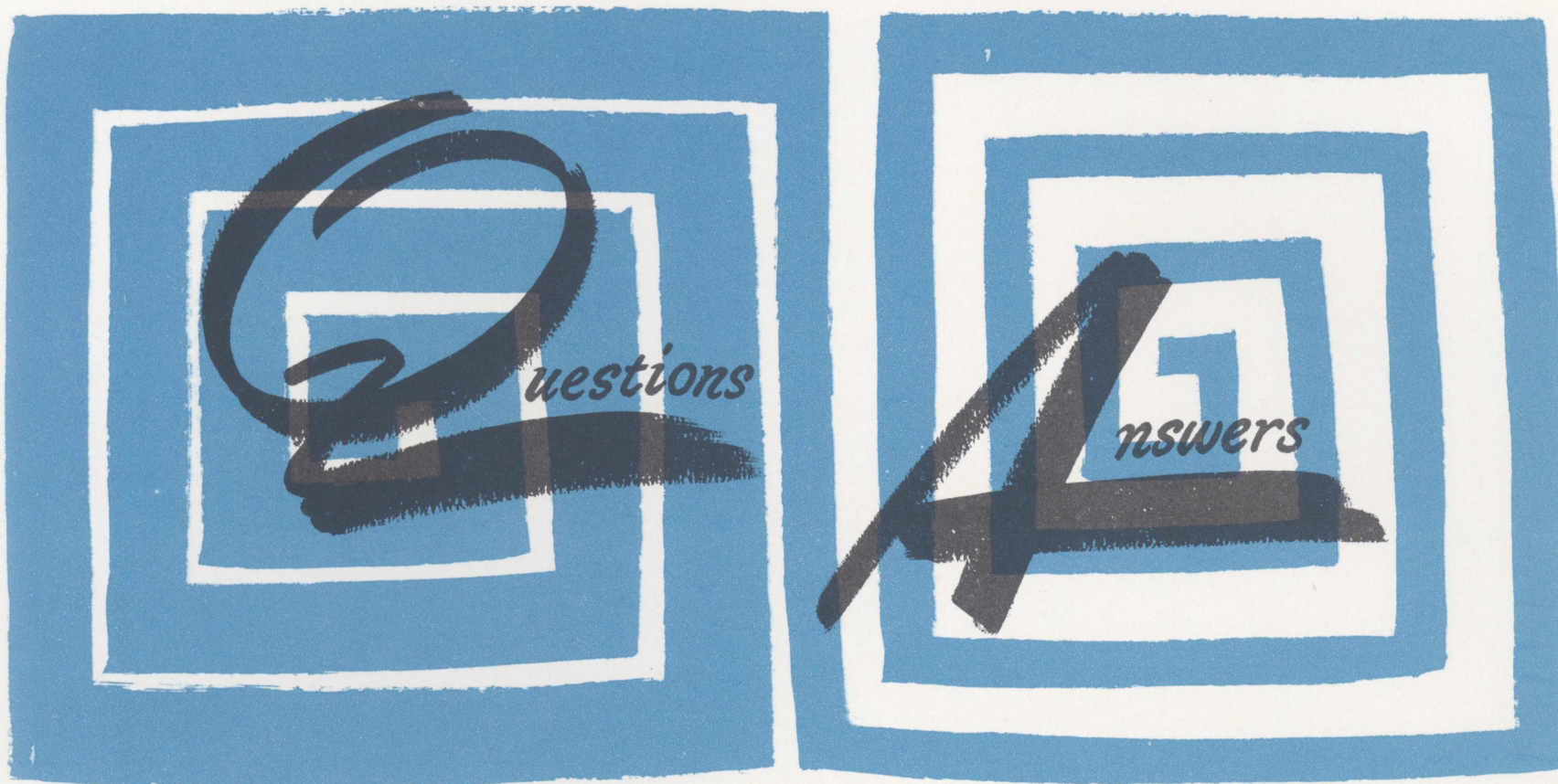
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QUESTION: Are there any psychiatric contraindications to the administration of bromides?

ANSWER: In addition to the physical contraindications to bromide therapy, chronic symptoms of emotional disorder—psychosis, neurosis, and especially alcoholism, may pose specific dangers with continued use of bromides. With stronger restrictions on the sale of barbiturates, bromides are being more widely used by individuals suffering from recurrent somatic complaints. Many such patients have symptoms which are primarily psychogenic, together with other indications of a disturbed emotional organization. They often resort to irresponsible self-medication, or prevail upon physicians to prescribe bromides.

Carefully supervised, bromide medication is of undisputed value, but because of the cumulative effects of the drugs within the system, those patients who reason that "if one dose is good, two will be better" may be inviting bromide intoxication. Studies made on normal subjects indicate a fairly high tolerance to bromides taken over a period of a few weeks. The people who make a habit of taking bromides, however, do not always control their self-dosage, either as to amounts taken or length of time involved. Chronic

headache and gastrointestinal discomfort may result from bromide intoxication, yet frequently the medicine is continued and the doses are increased. As intoxication progresses, the bromide concentration in the cerebral cortex becomes high and psychotic reactions result. Treatment entails elimination of bromides from the system, but bizarre mental symptoms often persist beyond the period of bromide elimination. Some cases of bromide intoxication might be prevented if physicians would let certain patients know that prolonged and indiscriminate use of bromides may aggravate the very symptoms for which they seek relief.

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QUESTION: Does adequate adjustment to military service indicate a similar degree of civilian adjustment?

ANSWER: A recent study into the pathogenic effects of returning home refutes this concept to some extent. The investigators have coined a term, "nostopathy" to differentiate the sickness attributable to returning home from its opposite, nostalgia, or home-sickness. Twenty-five selected veterans were studied with specific attention to their reaction to the prospect of returning home. The

symptoms of this group were found to be the result of homecoming, and not the result of having been to war. Some of these returning soldiers were conscious of their dread of going home, and could describe the onset of their symptoms, while others were completely unaware of the cause of their difficulties. Some of these men preferred remaining in combat to returning home. Since all of them had made good transition from civilian to military life, the home itself appeared to be the pathogenic factor. The study revealed that many emotional factors were involved: reluctance to assume responsibility, increased dependency, opposition to infantile treatment at home, injuries to self-esteem, decreased heterosexuality, increased aggressiveness, shame and guilt over behavior in the service, and others.

Since most of these men functioned at a higher level during war-time than in civilian life, the neurotic should not be overlooked as a potentially excellent serviceman. Pathological reactions to returning home are not restricted to soldiers; individuals returning home from prolonged hospitalization or imprisonment often experience similar negative reactions.

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Emotional Factors IN S



THE PROSPECT OF SURGERY arouses many fears and anxieties which the attending physician may not recognize. This failure can result in pre- or postoperative complications which cause both the patient and physician unnecessary hardship.

Because physicians are so accustomed to illness, it is understandable that they lose sight of the fact that surgery becomes an event of major importance in the lives of many persons. For some, life is divided into the time before the operation and the time after it.

Even well-informed people as a rule are somewhat fearful of surgery. Nearly every physician has had to recommend some sort of surgical procedure for another doctor. But even *these* patients do not always accept this verdict quietly and immediately. What factors are involved in these reactions?

The personality structure of the patient and his life situation influence the response to surgery. When both of these are stable and satisfactory, threats of any sort, including

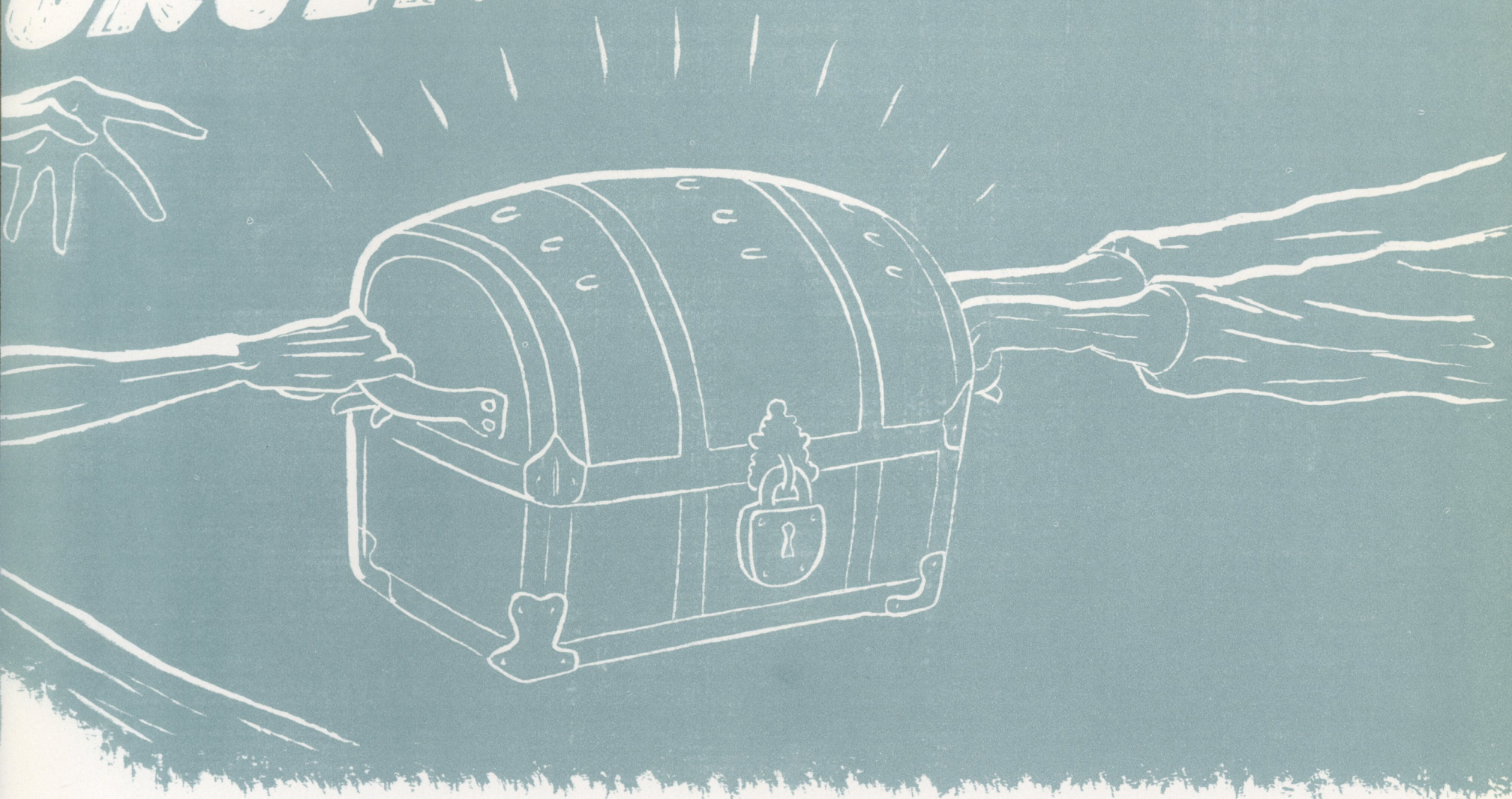
surgery, are dealt with more satisfactorily. When one or both of these factors are unstable, the patient will have greater difficulty in coping with any additional burdens.

Unexpected danger floods the person with sudden great excitement with which he must deal, but anticipated danger allows time for certain defense reactions to occur. Since surgery carries with it a threat of injury to the body and to life itself, the patient reacts to it as he does to danger from other sources. Deutsch finds that the more acutely indicated the surgery, and the less prepared the patient, the more apt is an anxiety reaction to appear in the postoperative period. On the other hand, patients who have had a pathological condition for some time, who have been on medical management, and who have been informed that surgery may be needed, have had some opportunity to get acquainted with this threat and to dissipate some of the fear. In those who have been well-managed, surgery does not have as unfavorable an emotional impact,

but is looked upon more as a relief measure.

The diagnosis, as well as the organ affected, is of tremendous emotional significance to the patient. When the verdict is cancer, the patient is much more likely to be overwhelmed with fear and depression than he is when the diagnosis is less foreboding. If the procedure is a mutilation, as in various amputations, the surgeon should expect emotional reverberations, even in the very stable individual. However, these reactions vary greatly according to the specific experiences of the patient, and a seemingly trivial condition or procedure often evokes startling and unexpected reactions of anxiety. This must mean that old, inner threats that depend on the pre-existing personality are aroused. One of these old anxieties is the fear of death, which anesthesia is particularly apt to revive. For some people, any loss of consciousness, even normal sleep, is vaguely comparable to death. This factor alone may be responsible for much of the anxiety, especially in general

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anesthesia. However, spinal anesthetic is also quite fearsome to some patients. This is consciously rationalized as fear of being permanently paralyzed. Some work tends to show that on a deep, unconscious level it is fear of punishment.

It is well accepted that irrational fear of punishment is a source of great anxiety during childhood. Much of this fear centers around prohibitions concerning the sexual organ, but part of this fear remains in the form of anxiety about *all* parts of the body. Hence any organ that has been diseased for a long time will have various emotions centered on it. If it has kept the person from certain satisfactions and accomplishments, this organ may be unknowingly regarded as a hated persecutor. On the other hand, if it gains attention and escape from responsibility

for the patient, it may be unconsciously overvalued. If the latter is true, a surgical attack on the organ, removal of this especially revered part, will renew the old unconscious fear of punishment. This old anxiety becomes even more evident if the organ in question is part of the genital apparatus. For example, the intensity of reaction which many men show when a simple vasectomy is suggested, is often out of keeping with the real factors involved.

Refusal of orchidectomy by many old men with carcinoma of the prostate, whose sexual life is long past, is striking evidence of fear of castration. It has been shown by careful psychiatric work that these same fears exist in women. Even though they outwardly seem to accept, or even want, pelvic surgery, many of these women develop neurotic

symptoms afterward. This less obvious emotional reaction in women should certainly be taken into account before recommending such procedures.

Other parts of the body have great psychological value. Threats to sight and hearing mean that not only is control of the environment by these modalities threatened, but also the erotic functions of looking and listening. It has been found that paranoid reactions occurred frequently in patients who had both eyes bandaged following ophthalmologic surgery. Removal of the dressing from the untreated eye alleviated the condition.

Another important factor in the individual's response to surgery is his emotional relationship to the surgeon. While on the surface it may be polite and friendly, the unconscious elements (the transference)

may be quite different. A great many people tend to act toward authoritative figures as they did toward their fathers. They may cooperate well with the doctor in order to win his approval. In certain neurotics, love is linked with pain and suffering, and these patients may actually ask for surgery as an unconscious striving for affection. Patients whose relationship to the father was marked by defiance may react this way toward the surgeon. It may be open rebellion in the form of refusing examinations, medications, etc., or it may be quite subtle. Seemingly stupid errors of judgment in intelligent patients, glaring memory failures, unexpected inability or failure to cooperate in examinations or treatment routines, are some of the signs of this silent, undercover warfare.

Because of the unconscious significance of surgery, psychic reactions of varying degree may sometimes develop during the course of the illness. Frank anxiety reactions may be seen with all the psychologic accompaniments of sweating, tachycardia, respiratory distress, as well as irritability, nightmares or anxiety dreams. The reaction may be a mild one or may amount to actual panic.

Reactive depressions are often seen, particularly after surgery which interferes with emotionally-charged functions, such as sexual activity. These patients complain of anorexia, insomnia and lack of interest. The surgeon should be especially careful of those patients who appear totally disinterested and withdraw from their environment. They may be acutely aware of what is being said, twist comments to suit themselves, and may attempt suicide.

In certain cases, this withdrawal may continue long after the patient has left the hospital. This was found to a considerable degree in patients who had undergone colostomy. Their lives became centered around the artificial anus and many developed compulsive behavior about the irrigation procedure. Anything that interfered with this was avoided and in some, social participation was impaired for a long period of time. Spillage in these people caused such profound loss of self-esteem and degradation that a frankly suicidal depression resulted.

Psychoses seem to be more prone to follow genital surgery, though many are seen in operations on the thyroid gland. A study of 23 such reactions showed that most occurred in people between 30 and 55, and appeared one to 15 days postoperatively, the greatest incidence falling between the third and fifth day. They tended to subside within a few days or weeks. When the reaction persists longer than this, it suggests that either schizophrenia or an organic psychosis is present.

Postoperative deliriums occur, especially in older people, or those who are given a good deal of sedation. Restlessness, irritability, and sensitivity to noise and bright lights usher in this reaction. Paranoid delusions, hallucinations and disorientation at night are common, and other symptoms are worse at that time too. In their confusion and bewilderment, the patients may commit suicide in an attempt to escape the delusions and hallucinations. Such patients are best managed by avoiding sedatives, and giving careful attention to adequate fluid, nutritional and vitamin intake, and quiet surroundings.

Functional psychoses, particularly schizophrenia, may appear following surgery. Severely paranoid persons may unconsciously regard surgery as a sexual attack—especially if the procedure concerns the genitalia or the rectum.

How are these various reactions best handled? As always, prevention is the easiest method. The surgeon does not have to be a psychiatrist to think of the patient as a person, instead of a diseased part. If he takes time for a private interview, he may get some idea of the patient's personality and his current life situation. If either of these present obvious difficulties, it may be wise to postpone elective surgery until the problems are worked out. When the surgical procedure is definitely decided upon, the patient will be greatly helped if the physician discusses with him the pre- and post-operative procedures and the reasons behind them. This will dispel possible apprehensions to the effect that things are not going well. The physician should also explain briefly and simply, the operation itself. Patients will get some information about surgery, even if it is incorrect,

since friends and relatives always have many erroneous conceptions to give them. The surgeon will have a much easier time forestalling this with voluntary explanations, rather than having to explain or minimize such ideas later. He must decide what to tell the patient with regard to grave diagnoses and prognoses. Whatever information he decides to impart should be given in a clear, frank, friendly way. It is important to avoid being obscure or misleading, because this will arouse more anxiety and distrust. It may be desirable to explain common misapprehensions about the consequences of the contemplated procedure. The patient should be encouraged to ask questions and to air his fears.

In the hospital, the anesthetist can do much to dispel the fear of anesthetic, which is often really the fear of death, by a reassuring discussion of the type of anesthetic to be used and the reactions that the patient will experience from it.

The nurse can be most helpful in getting information from the patient, as well as telling him certain specific things the doctor wants him to know.

The surgeon will find the psychiatrist a valuable aide in dealing with the highly neurotic or the psychotic patient. The psychiatrist should be consulted if the neurotic reactions are severe or if they fail to abate with ventilation and reassurance. When a psychosis is precipitated by surgery, the surgeon usually needs no admonition to call in the psychiatrist. The two should work as a team to expedite recovery.

The ultimate goal of all branches of medicine is a normally functioning person, rather than a mere functioning part, and the cooperation of all persons concerned with the patient should be focused on this objective.

Suggested Reading

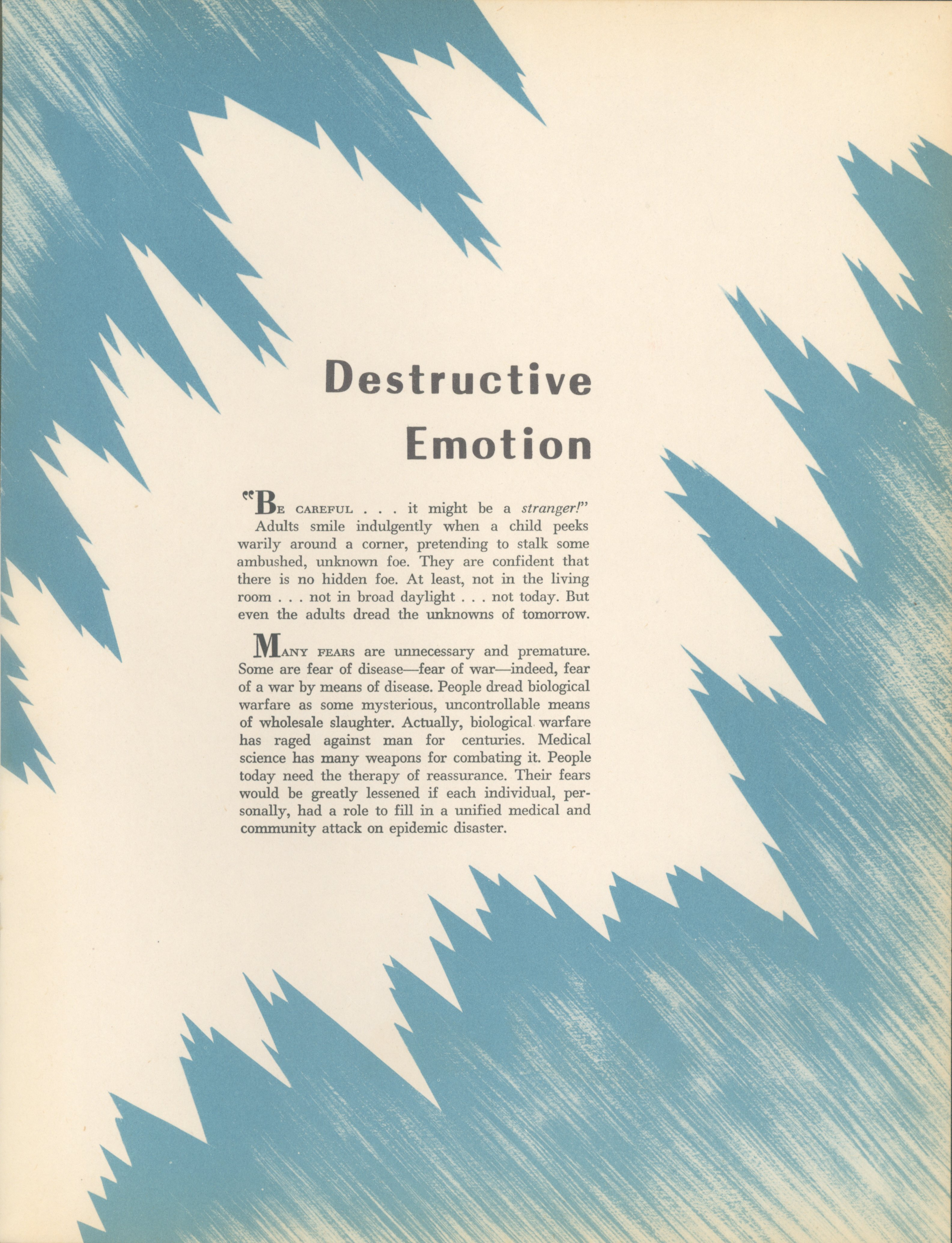
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Destructive Emotion

"BE CAREFUL . . . it might be a *stranger!*"

Adults smile indulgently when a child peeks warily around a corner, pretending to stalk some ambushed, unknown foe. They are confident that there is no hidden foe. At least, not in the living room . . . not in broad daylight . . . not today. But even the adults dread the unknowns of tomorrow.

MANY FEARS are unnecessary and premature. Some are fear of disease—fear of war—indeed, fear of a war by means of disease. People dread biological warfare as some mysterious, uncontrollable means of wholesale slaughter. Actually, biological warfare has raged against man for centuries. Medical science has many weapons for combating it. People today need the therapy of reassurance. Their fears would be greatly lessened if each individual, personally, had a role to fill in a unified medical and community attack on epidemic disaster.

"CANST thou not minister to a mind diseased,
Pluck from the memory a rooted sorrow,
Raze out the written tablets of the brain?"

MACBETH, Act V, Scene 3

